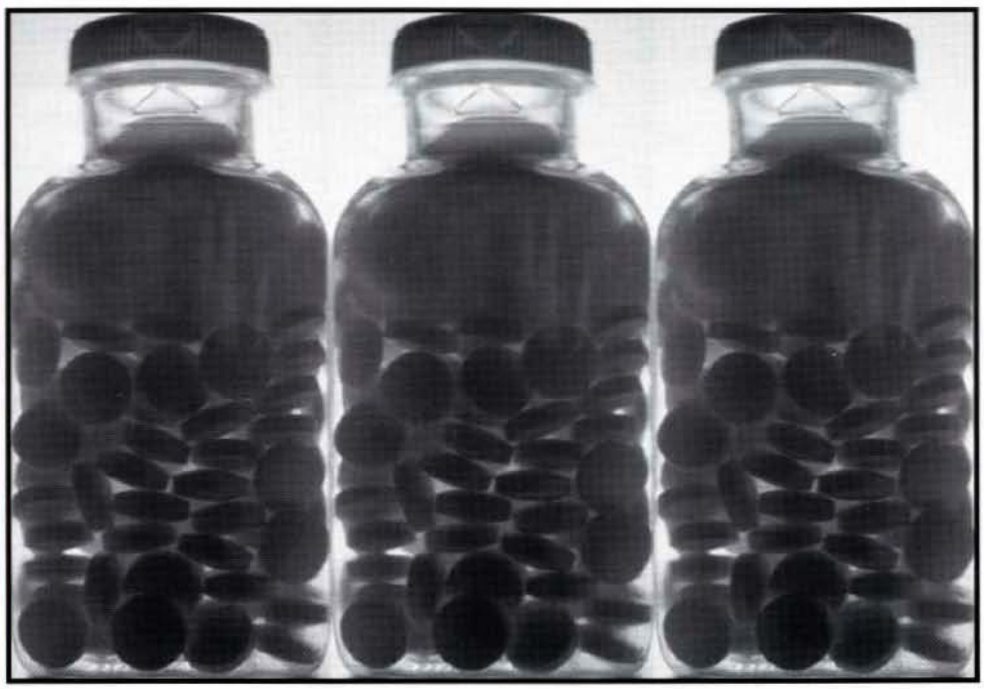
TuftScope

The Interdisciplinary Journal of Health, Ethics, and Policy

April 2003 Volume 3 Number 1



Original Articles

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TuftScope

The Interdisciplinary Journal of Health, Ethics, & Policy

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With recent advances in biotechnology and advanced medical techniques comes a multitude of ethical and philosophical questions, and a need for policy review. Conceived in the Fall of 2000 by undergraduate students, TuftScope brings together various students, academics, policymakers, and industry representatives to talk about pertinent healthcare and biosocial debates in today's world.

TuftScope, the Interdisciplinary Journal of Health, Ethics, & Policy, accepts original articles on government health policy, public health, bioethics matters, medical education, research in the mentioned fields, and other various issues dealing with the science and art of medicine or our country's healthcare system. The principle objective of TuftScope is to bring together seemingly different viewpoints, civic engagement, and bioethics to transform thoughts and ideas into active citizenship and working policies.

TuftScope is a recognized, funded student organization of Tufts University.

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Volume 3 April 2003 Number 1

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From the Editor

We are looking for students and young professionals committed to expanding the understanding and development of future leaders in bioethics, heath and public policy!

Dear Reader,

TuftScope: The Interdisciplinary Journal of Health, Ethics and Policy has been one of the fastest growing and most widely recognized student publications in recent years. In the three years since its inception, *TuftScope* has accrued a number of awards from the local to the international level, and it has started to integrate itself into a broad and active student bioethical and public health community. This year brings new leadership, new people and new ideas to *TuftScope*, as well as a new perspective on its vision and mission. We would like to bring together civic-minded and actively interested students the world over, with the hope that *TuftScope* can contribute ever more in-depth and varied views to our global student community.

TuftScope was founded in 2000 by a pair of enterprising undergraduates at Tufts University. The magazine has grown to a peer-reviewed journal that continues to strive to connect bioethics and citizenship. A year after its official recognition, TuftScope received the Tufts University Evergreen Award for best new student organization. That same year, the International Student Bioethics Initiative (ISBI) recognized *TuftScope* as an up-and-coming force in student health journals. Last year, *TuftScope* began to integrate with the national bioethics community, participating in the University of Rhode Island's honors colloquium: *Genetic Technology & Public Policy in the New Millennium*. We also began the innovative new project called JournalLine, which links student bioethics and public health journals nationwide. In a few short years, *TuftScope* has grown from a Tufts University community publication into one with a national and an international presence.

As the new Editor-in-Chief, I have consulted with our existing advisory board and past editors, resulting in a list of goals and aspirations for the upcoming year:

1) Focus our commitment to publishing public policy and philosophy/ethics-oriented papers

In the past, *TuftScope* has seen quality scientific, research papers and opinion pieces. We would like to concentrate our future on the active citizenship aspect of our mission. What problems exist in the handling of current issues in the healthcare and research worlds? How can they be fixed? We are looking for submissions that investigate these questions.

2) Expand our Peer Review base

We are also looking to increase the number of graduate students and young professionals on our review board. Articles submitted for publication must undergo extensive examination by our area-specific Peer Reviewers. As we look to refocus and broaden the range of subjects that we publish, our Peer Review Board must also be expanded.

3) Increase submission volume and quality

TuftScope would like to reach out to the vast and largely underrepresented undergraduate and graduate students, research assistants and public health workers who have something to contribute to national debate and discourse, but who rarely encounter a venue for publication.

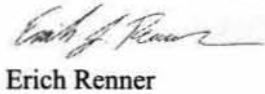
4) Expand JournalLine to include student journals from universities all over the country and the world

There is great potential in connecting student publications in the areas of health, ethics and public policy. In the future, we hope JournalLine can be used as a research tool, as a resource for curious individuals and as a networking tool for student publications, wherever they may be.

In order to achieve these goals, we must turn to you—our readership. We invite you to become a part of *TuftScope* and to help mold its future. If you are a student—undergraduate, graduate, medical, law or otherwise—and you have something to say, please submit a full article or a correspondence piece. If you have a bachelor's degree and are interested in what students have to say, become a part of our Peer Review Board. If you are part of a student-run journal, please let us know you are out there! We can include you in our ever-expanding JournalLine and connect you with other student journals nationwide.

TuftScope has come a long way in a few short years, and has contributed much to a vital and active environment of student discourse on health, ethics and public policy. With your help and the help of the world's many student communities, *TuftScope* can and will broaden its horizons and strengthen the foundation of knowledge and discourse on which the coming generation of leaders will build.

Thank you for reading,



Erich Renner
Editor-in-Chief

Information for Authors

Scope of Journal

The mission of TuftScope is to promote a well-rounded discussion of bioethical and health issues in today's society with an emphasis on active citizenship. TuftScope accepts original essays, opinion/editorial pieces, and research papers on topics including public & community health, government policy, health economics, bioethics, education, and the influence of technology. TuftScope's main goal is to achieve a thorough discussion of these issues in the context of active citizenship and effective policies.

Guidelines for Authors

Original articles, correspondence, and research are eligible for publication in TuftScope provided that they have not been published elsewhere, either in part or in whole.

Format:
Submissions must be submitted electronically in a word processing program. Files must be Microsoft Word with *.doc extension, or text with *.txt or *.rtf file extensions. Hard copies may be mailed to TuftScope, but electronic copies are required also.
Submissions are recommended to be 2000 - 2900 words in length, although no set limit exists. TuftScope, however, reserves the right to edit submissions for length. In the event that a submission must be edited, it will be sent to the author for approval before publication.
Please include a title page with title, author(s) name, affiliation, site of research (if applicable), sponsor of research (if applicable), lead author's mailing and e-mail addresses.

References:
Please use numeric notation for citations, and include the reference list on an attached page
An example would include:
1. Norton RA. The ethics of voluntarily stopping eating and drinking: A survey of Massachusetts physicians. TuftScope. 2002; 2:2-5.

Abstracts and Keywords:
Abstracts should be approximately 150 words in length and should summarize major points of the article.

Conflicts of Interest:
In keeping with current ethical standards of journal, authors must disclose all potential conflicts of interest, financial or otherwise.

How to Submit

TuftScope uses a submission management system to track manuscripts through the review process. To submit your manuscript, begin by logging-on to the system at http://www.tuftscope.org/authors. A web-based form is used to initiate your submission.
Address an e-mail message to submissions@tuftscope.org with a subject line of "manuscript." Attach your work, in the proper file format, and in the body of the e-mail enter the title, author(s), affiliation, and author(s)'s contact information. Omit all identifying information from your attached submission except for the email body.
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A "Submission Release Form" authorizing TuftScope to publish your article must be received before manuscripts can proceed to the peer review phase. This form may be downloaded at http://www.tuftscope.org/authors, by clicking on "forms." The author retains all copyrights to their article.

In the News

Link Between Obesity and Cancer Revealed, Americans Remain Ignorant

The International Agency for Research on Cancer estimates that being overweight and inactive accounts for one-quarter to one-third of worldwide cases of breast, colon, uterine, kidney, and esophageal cancer. Recent research, however, has elucidated the possible biochemical link between obesity and cancer.

Studies suggest that fat cells behave like endocrine cells, constantly secreting a wide variety of hormones and other growth factors into the bloodstream. "These substances send signals to other parts of the body… that...make it easier for certain cancers to initiate, and to grow," says Dr. George Bray, an obesity expert at Pennington Biomedical Research Center in Louisiana.

The pancreas of non-diabetic individuals at or near ideal weight produces low levels of insulin in order to break down food. It has been shown, however, that the tissues of many overweight individuals are less sensitive to insulin's effects. To compensate for this, their bodies produce more insulin, along with insulin-like growth factors that spur cell division. When cell division occurs more frequently, Dr. Bray remarks, chances of cellular malfunction increase, possibly leading to random mutations and cancer.

Experts therefore predict that excess body fat will ultimately be the main cause of hormonal cancers, including breast, prostate, ovary, and uterine cancer. In addition, the lining of the colon may be particularly sensitive because it is composed of cells that already divide at an extremely rapid rate.

The percentage of overweight and obese Americans has reached an all-time high of 64.5%, according to the ongoing National Health and Nutrition Examination Survey, published in the *Journal of the American Medical Association.*

Public awareness of obesity's link to cancer, however, remains dangerously low. In a survey commissioned by the American Institute for Cancer Research, only 6% of Americans surveyed mentioned obesity as a cancer-causing factor. They were more likely to mention exposure to chemicals, high-fat diets, sun exposure, and family history.

Physician Elected Senate Majority Leader

On December 23, 2002, William H. Frist, M.D. was elected Senate Majority Leader. In ascending to that house's most powerful position, Frist (R-Tenn.) replaced Senator Trent Lott (R-Miss.), who was rebuffed by President Bush and GOP senators for remarks that some perceived to be condoning segregation. The first practicing physician elected to the Senate since 1928, Frist was first elected in 1994 following a career as a heart surgeon.

Aiding a victim of a deadly shootout and rescuing a Capitol Hill tourist who suffered a heart attack, Frist was also in the news for helping victims at the scene of a highway accident the same day as the GOP announcement was made. "I accepted that authority with a profound...sense of humility, very similar to placing [a] heart into a dying [patient]," Frist said.

"Dr. Frist" is regarded an authority on health care issues among Republican colleagues. On February 14, Frist unveiled a Republican agenda including an unusually large number of healthcare items. The list includes capping medical malpractice awards for non-economic damages; banning late-term abortions, often referred to as "partial birth" abortions; adding a prescription drug benefit to Medicare; and approving $15 billion in AIDS treatment for victims in Africa.

Frist reserved his most passionate remarks for this last proposal, the only whose passage is nearly certain. "This little virus is only 22 years old but has killed 23 million people," Dr. Frist said. "And in the best of all worlds, it's going to kill another 45 million. And I want the history books 30 years from now to look back and say America stood up and changed the course of history,…[affecting] tens of millions of people, saving their lives."

Bush Proposes Medicare Reform

In his January 28 State of the Union address, President Bush called on lawmakers to add a prescription drug benefit to Medicare. "All seniors should have the choice of a health care plan that provides prescription drugs," Bush said.

Although details about the plan have not been released, reports indicate that the plan will provide a prescription drug benefit to seniors who enroll in certain HMOs or private health plans. In his budget request, the President has asked for $600 billion over ten years for the program. The ultimate outcome of the proposal remains highly uncertain, however, as prominent lawmakers on both sides of the aisle have criticized it.

Speaker Dennis Hastert (R-IL) called the plan "unworkable." Senator Charles Grassley (R-IA), Chairman of the Senate Finance Committee, which has jurisdiction over Medicare, said, "I won't draw lines on drug coverage...Seniors should have access to affordable prescription-drug coverage, regardless of the choice they make."

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FDA Works Toward Curbing Antibiotic Restistance

In the Sept. 19, 2000 Federal Register, the Food and Drug Administration (FDA) proposed to amend its regulations, requiring that all antibacterial drug products intended for human use be labeled with statements encouraging prudent use in order to reduce the development of drug-resistant bacteria.

This February, the FDA announced new regulations that apply to all systemically-absorbed human antibacterial drugs. Labels now advise physicians to use these drugs only to treat infections suspected to be bacterial, encouraging physicians to counsel their patients about the proper use of these drugs and the importance of taking them exactly as directed.

Many bacterial species, including the species that cause pneumonia, other respiratory tract infections, meningitis, and sexually transmitted diseases, have become increasingly resistant to the drugs used to treat them. About 70 percent of bacteria that cause infection in hospitals are resistant to at least one of the drugs most commonly used to treat them.

Several bacterial strains have even developed resistance to every approved antibiotic, and must be treated with experimental and potentially toxic drugs. According to the CDC, half of the 100 million prescriptions a year written by office-based physicians in the US are unnecessary because they attempt to treat illnesses against which antibiotics are useless, such as the common cold and other viral infections. Unnecessary use of antibiotics in hospitals is also reported as common.

The FDA's final regulation thus seeks to reduce the inappropriate prescription of antibiotics to patients with common ailments such as ear infections and chronic coughs, as efforts to encourage the development of new antimicrobials while preserving the usefulness of pre-existing ones remain at the forefront of the FDA's policy-making process.

Adoption of these requirements is an important milestone for the Public Health Action Plan To Combat Antimicrobial Resistance, a joint initiative of FDA, the Centers for Disease Control and Prevention (CDC), and the National Institutes of Health (NIH).

SARS Death Toll on the Rise

A new type of atypical pneumonia of unknown etiology has emerged from Asia. At the time of this printing, Severe Acute Respiratory Syndrome (SARS) has infected 2671 people worldwide and claimed 103 three lives. 148 of those cases have been reported in the United States, though there have been no US fatalities. Though scientists are beginning to ascertain the virus's identity and mode of transmission, a sure-fire cure does not seem to be in the immediate future.

The outbreak is thought to have originated from an infected medical school professor from southern China, who carried it to Hong Kong's Metropole Hotel and infected six other guests. Hong Kong officials believe the illness might be related through this professor to an earlier outbreak in Guangdong, China.

The disease may be spread by droplet transmission. When a person with the disease sneezes or coughs, droplets containing infectious material are expelled into the environment. Another person can become infected if the droplets come into contact with that person's mucous membranes. This means that infection can occur through direct inhalation of the droplets, or by touching a surface contaminated by them and then subsequently touching mucous areas like the eyes or mouth.

At onset, the disease resembles the flu. Marked fever, chills and body aches are the most common initial symptoms. It progresses to include a dry nonproductive cough, which may eventually impede oxygen uptake into the blood. According to the National Centers for Disease Control and Prevention (CDC) website, 10%-20% of SARS cases will require mechanical ventilation because of this inability to take on sufficient oxygen.

Scientists are trying to isolate the disease's cause, hoping that knowledge of its origin might lead to a cure. Efforts thus far, however, have produced conflicting results. Early reports from World Health Organization (WHO) network laboratories identified SARS as belonging to the paramyxoviridae family, which includes the viruses responsible for mumps and measles. CDC electron microscopy indicates that the disease is the result of coronavirus. Coronaviruses cause disease in both animals and humans, and may be treatable by anti-viral medications. CDC is investigating those possibilities. Still more recent reports emerging from China have pointed to a bacterium related to chlamydia as the cause. Efforts at finding a cure will likely be stunted until precise cause of the symptoms can be ascertained.

Until that time, public health leaders are focusing on awareness and containment to combat SARS. Informational pamphlets are being distributed to all passengers arriving into US airports from SARS infected areas. They include information on areas that are infected, on identifying early symptoms of the disease and on whom to consult if infection is suspected. CDC and WHO have even taken the unusual step of recommending cessation of non-essential travel to infected areas of China, Singapore and Vietnam. According to Dr. David Heyman of WHO, "... this is the first time that this has been done, at least in the past 12-13 years."

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SOCIAL CONSTRUCTION AND THE SELF: A FOUCAULDIAN PERSPECTIVE ON BIOETHICS

Spencer Davis

"Medicine must no longer be confined to a body of techniques for curing ills...in the ordering of human existence it assumes a normative posture, which authorizes it not only to distribute advice as to the healthy life, but also to dictate the standards for physical and moral relations of the individual and of the society in which he lives."[1]

-Michel Foucault

Michel Foucault's investigations into the relations of knowledge and power in society defied the trends of his contemporaries, leaving a body of work behind that has yet to fully permeate the academic consciousness. His career cut short by death in 1984, he left several projects unfinished, giving us considerable room for conjecture as to the course his writings would take. This incompletion, combined with the open-ended nature of his existing works, has allowed current thinkers to take his ideas in numerous directions Foucault himself never considered. Indeed, Foucault's call for a reevaluation of the historical evolution of our personal identities within the institutional framework of modern society opens more lines of inquiry than it answers—and therein lies its strength. Thus the application of Foucauldian ideas to a vast array of studies is possible.

Foucault wrote his final works in the early 1980s, before the wave of biotechnological advances that would bring the study of bioethics to its current level of popularity. Had Foucault lived a little longer, it is at least conceivable that he would have turned his attention towards this relatively new field, given his interest in the interactions between medicine and the social sciences. In his concepts of biopower, governmentality, and the medical gaze lay obvious ramifications for bioethical inquiry.

So what would a Foucauldian bioethics involve? How would one reconcile Foucault's hostility towards ideologies with a systematic approach to the questions bioethicists often face? How would such a bioethics address such issues as the doctor-patient relationship, genetic engineering, and the AIDS crisis?

Such a project obviously extends well beyond the scope of this paper. What I intend to present is not a systematic development of a Foucauldian bioethics, but rather an introduction to the relevant questions one must ask in attempting such a concept—a prolegomena if you will. It is my contention that a Foucauldian bioethics would be possible, and potentially very fruitful in shedding new light on dilemmas that have been rendered stagnant by more traditional ethical theories. This would not be a bioethics in a typical sense, however—it would offer no definitive answers to particular issues, it would make no claims to liberate the patient or to monitor the advance of science, it would ignore traditional moral sensibilities based upon religious or political ideologies, and it would offer the individual little or no direction in making personal choices. Rather, a Foucauldian bioethics would focus on the effects that medicine and biotechnology have upon the power relations within a social structure defined by institutional controls. It would ask questions about the nature of our new biological knowledge and how it may be used to define us as individuals and subjectify populations. It would examine how the fields of medicine and genetics came to be morally problematized in the first place. It would endorse bioethics as a practice of truth-telling in one's relationships with society and one's self. And it would suggest bodies, rather than ideas, as the rallying point for an ethico-political revision of our social structure.

Foucault used the term 'gaze' in reference to the medical perception of disease. With this visual metaphor in mind, let us attempt to turn our gaze upon bioethics, through a Foucauldian 'lens'.

Foucault's Genealogy of Medical Perception

Foucault's most extensive foray into medicine came in his 1973 book, The Birth of the Clinic. Although it would be several more years before his History of Sexuality series would offer the mature form of his ethical perspective, The Birth of the Clinic revealed Foucault's early views on science and how it affects

the social structure. In this exploration of how medical knowledge was shaped within eighteenth and nineteenth century France, Foucault looks at the often-neglected relations between science and politics and the mutual impact they have upon one another. As a political institution, the modern field of medicine would have unseen effects upon the identity of the individual, and along with other social institutions (psychiatry, the prison, education, sexuality) would bring about a new form of 'governmentality' based upon the control of life rather than the sovereign threat of death. In the course of exploring these notions, Foucault introduced several key concepts that will have ramifications for a bioethics.

Foucault refers to his concept of medical perception as the 'Gaze'. By this he means a complex epistemological notion of the doctor's 'way of seeing'—a style of perception whereby the doctor observes the diseased patient in his/her individuality. Now we need not fully discuss the complexities of this 'Gaze' to posit a bioethics, though a few points should be made before proceeding.

The Gaze is not solely a visual perception, as it sounds; in its complete form it takes advantage of all of the senses—touch, sight, sound—in an attempt to understand the patient and their condition. Foucault draws an analogy between the physician's Gaze and the reflection of the philosopher; both presuppose an objectivity in which the thing studied may be perceived in its totality and reflected in language. This linguistic element will have major ramifications within the knowledge-power structure generated by medicine.

The Gaze comes in where traditional analysis ends. It surpasses the limits of physiological knowledge, observable measurement, and classification, and takes in the individual case. It is the point at which experience enters the medical perception. The importance lies in this acknowledgement of the patient as an individual, for an individual—as part of a population—will be the focus of control in Foucault's notion of governmentality. The individual is to be understood as a body, and as such the point of counter-attack against power structures must also lie in the body.

The Gaze itself plays into these power structures, for it is supported by the institution of the clinic.[2] The clinic, as just one piece of an institutional structure, is a link in a vast web of 'technologies of power' which subjectify the individual and control him, and as such, the Gaze is endowed with political power, and the physician—in administering the Gaze—has the power of decision and intervention, backed by this very same social structure.

This institutional concept of medicine came about under the restructuring of the medical discipline as a 'medicine of the state' in the eighteenth and nineteenth century. State-administered, social medicine was a response to the problem of the epidemic, a problem which took on a much greater economic importance with the rise of capitalism. I previously made mention of the 'body' with respect to the patient; the rise of social medicine also corresponded with the body, in this case the social body. Governments in the eighteenth and nineteenth century began to view populations as the focus of control, and individuals as units of productive force, and medicine became one of several tools with which to control this social body. Thus a biopolitics was born, focusing on the bodies of individuals within the larger social body, and this biopolitics utilized medicine as a strategy—a 'technology', as Foucault calls it—of power. With the power of a nation rooted in its economic capacity, the epidemic presented an obvious problem with which the new biopolitics must deal.

Social medicine did this through a variety of mechanisms.[3] 'State medicine', as it was first developed in Germany, utilized statistics on birth and mortality rates to design a system for the improvement of public health. An integral facet of this 'state medicine' was the Medizinischepolizei, a medical police. Through systematic state-wide observation of sickness, standardization of medical education, and administration of health care, the German government sought to increase its power in relation to its neighbors by improving the health of its labor force. Doctors took on the role of administrators for the first time under this medical police, endowed with the power to decide who would receive funding, and thus treatment.

France and England would adopt their own forms of social medicine, albeit on different scales. France's focus was on the urban level, the growing hub of commercial activity in the revolutionary era. The city had an economic importance, but also a corresponding vulnerability to epidemic, derived from a larger population living in closer quarters. Thus sanitation and hygiene attained a new importance under the urban medicine of France, and quarantine became the strategy for dealing with disease, a strategy which would have a profound impact upon the development of medical knowledge. Meanwhile, England's system of social medicine, a 'poor people's medicine' as it were, recognized poverty as a danger to the work force, which consisted primarily of the lower classes. The French Revolution had shown that the lower class had established itself as a political force as well. Thus a tax-supported welfare was established in England as a means of simultaneously maintaining the eco-

nomic power of the nation and controlling the poor classes in the interest of the rich. The French system, in comparison, made no distinction between classes in how it administered health care. The philosophy of the English system would be the one to endure to the present day, leaving the upper classes to approach medicine through a free-market system, but the French and German systems had significant effects upon the problematization of medicine which we cannot ignore in a bioethical study.

What matter most for our purposes are the economic causes behind social medicine. Modern social medicine is framed as a beneficent mechanism fueled by the moral responsibility of the state to care for its citizens. Foucault's genealogy suggests an entirely different purpose to social medicine, one of control and utilization rather than of beneficence.

The concept of governmentality should not be forgotten as we now look closer at the development of the medical Gaze, for it is integrally tied to the techniques employed in both the application of a public health care system and in the evolution of medical knowledge itself. Three important shifts in the development of social medicine should be highlighted: (1) the shift in the localization of treatment; (2) the educational shift and the corresponding professionalization of medicine; and (3) the shift in the philosophy of medical treatment itself.

One of the first changes brought about by the urban medicine of France was a shift in the localization of treatment. The hospital was seen as a growing danger, a place where disease ran rampant, and a place where patients were brought to die rather than to be cured. Furthermore, it was seen as an unnatural setting in which to observe the disease, and so its utility as a place of learning was also compromised. The new philosophy of assistance was linked to the capacity of the individual as a worker, and so medicine must embrace a mode of treatment aimed at restoring the patient to this capacity. The conception of the hospital as a place of death would no longer do. So treatment was relocalized within the family, with the home as the 'place of life' that the hospital could not adequately provide. This lightened the economic burden on the nation as well, with funds diverted away from the housing capacities of the hospital and into the restoration of the patient's health and his labor capacity. The family was seen as the proper place of compassion, and the nation's role was one of assistance rather than care (another sign of the irrelevance of beneficence as the justification of early social medicine).

Though this system of family care did not last long, its importance in the changing social structure should not be overlooked. An economic parallel was drawn between the governing of a nation and the governing of a family. By placing the burden of care in the family, and tying this care with government funding, a crucial link was made: the family became the link between the individual and society. Later, the family would become the locus of statistical information, the place in which the government simultaneously gathered information on the individual and deployed a medico-ethical regulation of the population, based upon the social norm. The family became a conduit, sending information about the individual outward, and transmitting a juridical social control inward, a control based upon a biological understanding of the body legitimized by a medico-scientific discourse. We will return to the concept of normativity within this framework later.

The localization of treatment was shifted several more times, most significantly towards the clinic, where treatment coincided with a new focus on medical education which downplayed the importance of theory in favor of a practical, experiential knowledge of the physician. The clinic became the seat of learning under a newly expansive Gaze based upon a 'collective consciousness' of the medical profession.

And so we reach the second major shift of social medicine, the shift in the educational philosophy of the medical profession. Prior to the clinical age, aspiring doctors were given a strictly theoretical training, with little or no experience in treating patients, and there was no level of certification required to practice medicine. This was all changed by the French government. With a stricter regulation of who could teach and practice, medicine became professionalized for the first time, and was solidified as an institutional component of governmentality.

Meanwhile, within the clinic, theoretical shifts were taking place which would finalize the transition towards a scientific medicine. The individual body was now seen as point of elucidation upon the processes of disease. But here, perhaps, arose the first moral dilemma of clinical medicine: how to justify the use of the patient as a learning tool. It is a question of treatment versus research, a question which is no less relevant in today's drug studies. The patient came to the clinic seeking help, but learning was quite often the primary focus of the clinic, and the individual was seen as a means of furthering the common good through the knowledge his body could provide. The justification of this was seen in the nature of the doctor-patient relationship as it was then understood. This was a non-contractual relationship; the contract was instead seen in the relationship

between the patient and society. The patient sought help from society when he entered the clinic, and it was society's knowledge that may cure him. Therefore, he had an obligation to contribute to that knowledge, in the same way that any knowledge used to treat him stemmed from earlier patients. Keep in mind, this was a justification posited by those who funded the state medicine, i.e. the rich, and they did so upon utilitarian rather than beneficent grounds.

But the diseased patient was not the only object of knowledge for the new medical Gaze; the deceased patient had perhaps even more value. Dissection of corpses, previously shunned by the moral and religious sensibilities of society, attained acceptance during this time, and a physiological understanding of the body now became a vital component of medicine. To reach this point, a shedding of traditional moral values—based largely upon custom and religion—was necessary. So we see an early example of the secularization of morality in the interest of science. The new medico-scientific discourse had already attained such a level of influence within the new social structure that it could legitimate or refute ethico-moral values. The moral slate was thus wiped clean by science, leaving a blank page upon which the new biopolitics could construct its own ethics. Of course, the dissection of corpses alone was not the transition point for the scientific secularization of society, but it is certainly one example of a shift in social values which must have already been underway.

Moreover, I would argue that when medicine erased certain preexisting moral conditions in the interest of the advancement of its own knowledge, a need was left for a new moral framework within which it could operate—a need for a biomedical ethics. Without a definitive point of orientation for an ethical opinion, society nevertheless felt the need to attach a moral significance to many operations within the medical field, and so looked for a system upon which to make judgments. Hence, medicine and the biological sciences, one could argue, were problematized in the modern sense at the point when medicine became a science authorized to surpass preexisting moral values. But does this mean that modern bioethics is a response, a counter-attack, on the part of the population, against the mechanisms of biopolitics? I would argue that some positions in bioethical debate—particularly those of anti-biotechnology factions—reflect a certain desire for a liberation from biopower, though the methods of ethical discourse used in such arguments fail to escape the constraint laid out by governmentality. But I will take up this issue in further detail later.

I return now to the third major shift of social medicine, the shift in the philosophy of medical treatment. While the dead body was seen as a tool for the expansion of knowledge, death was still to be avoided at all costs within the framework of biopolitics, for at death the value of the individual, in terms of his labor capacity, was lost. In fact, the interest in studying the dead could be seen as an attempt to hedge the losses of the individual and derive at least some productive force from him, in the form of knowledge. At any rate, it was in the interest of the nation as well as the individual to cure the patient, and so a medicine of life—and health—was essential. Medicine must

> "embrace a knowledge of healthy man, that is, a study of non-sick man and a definition of the model man. In the ordering of human existence it assumes a normative posture, which authorizes it not only to distribute advice as to healthy life, but also to dictate the standards for physical and moral relations of the individual and of the society in which he lives."[4]

In this medicine of health, the role of medicine is dramatically expanded into all aspects of the individual's life. It is authorized with an ethical force, and may regulate not only the physical condition of the patient but also his very lifestyle. Backed with biopolitical force, medicine becomes a mechanism of control over the healthy man as well as the sick.

Medicine exercises this force through the 'normative posture' Foucault mentions. The Gaze not only perceives the individual patient's condition, but also compares him to other cases and shares this information through the discourse of medical terminology. The collective medical consciousness thus agrees upon a 'norm', and every individual is considered in relation to this norm. This normativity is the central tenet in Foucault's philosophy; it is the means through which the individual is subjectified, it is the means by which biopower attempts to legitimate itself, it is the link in the methodology of all disciplinary institutional structures, and it is the glue which holds together the power structures against which we must fight. Normativity brings together the axes of knowledge and power and forms an identity for the individual that can be controlled. We each define ourselves in relation to a social norm which is in turn defined by a medical discourse. Our identity is constructed in terms of how far we each deviate from a norm: a norm of health, a norm of intelligence, a norm of material wealth, a norm of physical ability, a norm of

ethnic background, a norm of sexual behavior, a norm of moral integrity. Governmentality defines this norm through discourse, setting up a structure under which we judge ourselves within the constraints of this same discourse.

So when Foucault speaks of medicine as a discourse of 'normative posture', this is not a light claim. He is seating the very basis of modern politics within the origins of medical discourse. He is framing our entire social system upon the physical and moral direction prescribed by an all-expansive notion of medicine. And if our entire social structure is defined in these terms, then of course our ethical values, as a part of this social structure, will be defined likewise. A Foucauldian bioethics will therefore serve a rather different function than a traditional bioethics: it must take into account the power of normativity, and it will recognize medicine not only as a subject of ethical discourse, but also as mechanism of subjectification, shaping our ethical values before we can even attempt to shape medicine's own. In effect, if we are to question the values of medical practice, we are going to have to escape the subjectification placed upon us—no easy task, to be sure. At any rate, if a Foucauldian bioethics is possible under these terms, Foucault himself would certainly agree that it must take place at the level of the body, the seat of all counter-attack against power structures.

With our overview of Foucault's historical genealogy of medicine sufficiently completed, let us now look at Foucault's ethical philosophy as he presented it in his later years, for when we incorporate this with his earlier works on knowledge and power structures, we find a unique concept of the ethical life from which our bioethics might advance.

Parrhesia and Ethical Practice

In lectures given during the final years of his life[5], Foucault explored the ancient Greek notion of parrhesia, and the result was a suggestion of an ethical practice which may escape some of the difficulties presented by the knowledge-power structures of society. Parrhesia is a particular practice of truth-telling as a way of life, found in the works of many notable Greek philosophers, but most strikingly demonstrated (at least according to Foucault) in the lifestyle of Socrates.

Parrhesia is defined within the contexts of several types of relationships inherent to its practice. First and foremost, it involved a relationship between the speaker and what he says. It is an attempt to ascertain the truth as one sees it, and to reveal it in its most truthful sense; it is an openness of mind and heart, revealed through non-rhetorical, direct discourse. Furthermore, it involves a relationship between the speaker and the interlocutor, in which the interlocutor is always in a position of power over the speaker, and in which the interlocutor will not like the truth that is offered. Necessarily then, the practice of parrhesia involves a fundamental level of risk.

The version of parrhesia I discuss here is a political parrhesia. Though parrhesia was a practice of free speech within a democracy, the Greeks perceived it as a threat to this same democracy, by the fact that all were eligible to practice in this speech as equal citizens, but few would be effective in it. Thus, the voices of the ignorant would most likely drown out the voices of the competent, leading to tyranny within society. Indeed, the parrhesia of the ignorant would most likely be the one respected, since it would present a truth the people wanted to hear. The critical parrhesiastes would be denounced by the public for the simple fact that his opinions refuted the accepted position of society.

Therefore, political parrhesia was considered problematic, and gradually evolved towards a more personal, ethical form. In this ethical parrhesia, the question became one of whether the truth (logos) one believes corresponds with the life (bios) one leads. Though there were several modes of such a parrhesia, Foucault seems to favor the one practiced by Socrates. It was a form of teaching involving the relationship between two people, in which the parrhesiastes sought to overcome his own self-ignorance about his situation by presenting his truth to an objective outside party. Socratic parrhesia leads to a certain notion of the 'care of the self', an idea presented earlier in the History of Sexuality Vol. 3, suggesting a point of connection between these lectures and Foucault's wider project. Parrhesia is conceived of as a healing practice, a method of restoring one's ethical life through an honest self-examination of the relationship between one's values and one's actions.

Foucault goes so far as to suggest that our own modern moral subjectivity is derived from this practice of parrhesia so conceived, but is this method really meant to apply to an impersonal field of problematization, such as bioethics? Or is it a more personal activity, incapable of evaluating moral dilemmas on the social level?

A hint of an answer to this question lies in the analogy Foucault emphasizes between parrhesia, medicine, and nautical navigation. Both the techne of medicine and the techne of navigation involve a combination of theoretical and practical knowledge; of course, we know this much from The Birth of the Clinic. But more interestingly, Foucault points out that both skills require a single person (the physician or the pilot) to

make decisions which others must obey in order to achieve a desired end. This puts both arts back within the realm of political situations, and suggests that parrhesia is a useful means at arriving at the truth of one's own knowledge and relating this truth to others in society—in short, to convince them of the truth of your judgment. This seems to make parrhesia a very relevant practice within ethico-political discourse and the particular fields of problematization defined by institutional structures.

In his closing statements on parrhesia, Foucault finally mentions the connection between power and parrhesia he has implied all along. The problem of recognizing the truth, and the truth-teller, is the fundamental problem in the Western critical condition. It is a problematization of truth itself, and as such would seem to precede the problematization of particular fields. So, when we confront the ethical and moral truths of medicine and biotechnology, we presuppose a problematization of truth which must be confronted prior to and during our ethical discourse. As we continue exploring this Foucauldian bioethics, we must not forget that at all times, being critical involves a questioning of truth, and a questioning of how we recognize truth in accepted social discourse and in our own words and actions.

Enough of a theoretical background has now been laid out so that we may examine how these concepts would apply to the specific study of bioethics. So let us turn to the present state of affairs in medicine—and biotechnology as well—and see how Foucault would perhaps present the situation in light of his articulated views on ethics and politics.

Foucault and Modern Bioethics

Before proceeding further, it may be wise to summarize this complex interrelation between medicine, ethics, and politics which I have presented so far. The problem, according to Foucault, is that medico-scientific discourse has been used as a mechanism of control under a governmentality which subjectifies the individual by defining him in relation to a social norm. Thus, any ethical discourse is already biased by the constraints of the biopolitical institutional structure. An ethical life, then, to be truly effective must find a way of stepping outside of this discourse. It must instead focus on a healing practice of the 'care of the self', which seeks to reconcile the way one lives his life with the truth he accepts through critical self-reflection.

So what does all of this mean for modern bioethics? It means that normativity is a primary target of ethical discourse, albeit one that defends itself covertly through the same ethical discourse used to attack it. It means that institutional revision becomes increasingly important within the social framework, for these institutions are the sources of control. It means that a restructuring of the medical gaze once again becomes necessary, for medicine is itself one of the institutional structures of biopower. It means that reforms must focus on physical, corporeal bodies rather than ideologies. But most importantly of all, it means a stronger focus on a bioethics rooted in individual practice, not in all-encompassing political solutions. Policy-making will do little good here; bioethics must start on the level of the individual and work its way upwards towards a reformulation of the social structure.

Perhaps concrete examples would clarify this argument. Let us examine several key bioethical issues in turn to see how a Foucauldian bioethics would approach them.

The Doctor-Patient Relationship and Knowledge-Power

The doctor-patient relationship has long been regarded as a fundamental issue in medical ethics. Most contemporary discourse focuses on the autonomy of the patient and the beneficent responsibilities of the physician. An entire set of ethical dilemmas arises concerning the doctor's treatment of the patient: what kind of treatment is appropriate for terminally-ill patients? To what extent should the doctor overstep the wishes of the autonomous patient who makes irrational decisions about treatment? How should the doctor prioritize allocation of limited medical resources, such as transplant organs? On what criteria should economic considerations affect treatment decisions? Should treatment ever be withheld during medical research? How can the patient's consent be legitimately obtained to take part in experimental treatments?

All of these questions are commonly framed in the context of the relationship between doctor and patient. But we forget that this relationship takes place within the power relations laid out by governmentality. The doctor is in a position of power over the patient—this much is commonly discussed in bioethical literature—but the doctor is also himself a subject of power. He is trained to approach problems through an accepted mode of critical analysis, and to frame his diagnosis in a certain style of medical discourse based upon a scientific norm of the individual. Moreover, he must take into account economic factors when deciding upon treatment—in short, he is deciding who is worth the cost expended by the rest of society, and who is not. And in cases of experimental treatment, ethical issues arise concerning the use of the individual as an object of

research, in which the gains of the population must be weighed against the possible sacrifice of the individual life. Under such a light, these bioethical questions start to take on a much more Foucauldian tone.

Furthermore, a Foucauldian notion requires us to take into account the fact that ethical discourse is itself firmly based in pre-existing social conditions. Traditional bioethics often focuses on individual dilemmas or specialized fields of inquiry, ignoring the broader social structures which gave rise to these dilemmas and thus leaving the foundations of problematized areas intact. Eugenia M. Porto criticizes this bioethical trend on Foucauldian grounds, and in particular attacks humanist trends in medical education which place the burden of ethical practice entirely upon autonomy and beneficence in the doctor-patient relationship. Such solutions ignore the more significant problematic foundations of medical ethics. Porto makes the point much more succinctly:

> "What we are witnessing is an effort by medicine (aided by the field of medical ethics) to fashion a discourse that appears to recognize patient autonomy and sovereignty but which in fact may only hide and so further support a dehumanizing treatment of persons...we merely generate a humanistic rhetoric that contradicts the very practice we describe."[6]

Porto's recognition of the Foucauldian problem as it relates to medical ethics highlights some important points upon which a bioethics could be formulated. Among these is an argument against the so-called biopsychosocial model of medicine, which tries to reconcile problems by taking into account the mental and social background of the patient. Such an approach only further subjectifies the patient by laying out whole new areas of normativity on which he may be judged. The point that Porto—through a Foucauldian interpretation of the issue—recognizes is that deeper scientific discourse cannot be a solution to a problem which is itself rooted in scientific discourse. More knowledge is not the answer; instead, we must ask ourselves who should possess knowledge and define how that knowledge should be used.

This seems to suggest that the individual patient should take up a greater responsibility in his treatment, informing himself of his condition and increasing his own power through medical knowledge of himself. This solution, while intuitively attractive, easily leads to a misinterpretation of the Foucauldian problem though. Thanks to the internet and other advances in information technology, today's patient is arguably better informed about his condition than in any time in history. But we must remember that his knowledge is based in the same medical discourse as the doctor's. And as we recognized, the doctor is no less a subject of power than the patient. So in effect, this solution would only cut out the middle-man.

So does this leave the individual no recourse? Can neither the doctor nor the patient escape the institutional structure of discourse in order to participate in a meaningful ethical reform of medicine? Porto seems to imply this, arguing that medical ethics must focus on the broader socio-historical context under which medicine was problematized before real progress can be made ("Doctor-patient relationships cannot be made satisfactory by new hospital policies or interpersonal skills"). In other words, changes in medicine will not be effective if corresponding social institutions are not also changed.

While Porto's point is certainly legitimate with respect to Foucault's earlier works, it does not take into account the growing emphasis Foucault placed upon the notion of parrhesia in his final years. It would seem that the individual had an ever more important role in Foucault's ethical reform, through the practice of his own life and the critical pursuit of truth. If Porto means to suggest that interpersonal relationships are not relevant within a Foucauldian bioethics, I would have to disagree. Power is a relational function within Foucault's philosophy, constantly in flux between parties[7], and so revising power relations is certainly a feasible way of doing ethics. Through the parrhesiastic relationship we may simultaneously ascertain our own ethical truths, compare these truths with the objective opinions of another party, and take part in a political process whereby we communicate our truths to society at large.

So, the patient, in aquiring knowledge about his condition, indeed improves his situation within the ethical framework of power. But the danger to be avoided in this is the acceptance of the same medical categorizations that the physician uses. The patient, in informing himself, must constantly question the medical discourse he attempts to describe himself by, and resist normalizing himself through categories which would deny him the power to ascertain his own individual identity. Porto, though making a very relevant argument, neglects this important point.

However, I should not be mistaken as disagreeing with Porto's more crucial point, which is that ethical

questioning must look deeper and question the very social structure it is a part of. Porto's call for social and institutional reform most definitely occupies a key role within a Foucauldian bioethics. I amend this argument only by asserting that individual relationships are also a crucial part of the process (though Foucault would certainly oppose the humanist education by which medicine has sought to incorporate this). The doctor-patient relationship cannot be revised through policy or education; rather, it must be a personal and private practice between the two parties, through which each critically evaluates ethical truths and relates these to the other through open communication.

Genetics and Bodies

The science of genetics did not approach its era of dominance until the time of Foucault's death, but it would be no great assumption to say it would have been a topic of much interest for him. The science of genetics has the potential to be the culmination of biopower—the exact knowledge of the human norm, and the complete control of the life process itself.

The Human Genome Project, initially proposed in 1986, began not long after Foucault's death. The goal was a complete sequence of the genetic information which codifies the biological existence of the human organism. Now, what is meant by the term 'biological existence' that I use? In its most precise sense, it is the protein composition of the human being. Proteins make up the majority of the physical composition of biological tissue, and also carry out vital functional roles in metabolic processes. So when we speak of the 'biological existence' of the human being, we mean his physical composition, but we also mean the life processes which maintain it. And through a growing understanding of how biochemistry relates to behavior and psychology, we must also incorporate at least some mental aspects of the human being when we speak of his biological existence.

So it would be no stretch to maintain that the Human Genome Project was an effort to discover the biological definition of what it means to be 'human'. In Foucauldian terms, it was an effort to reach the most exact definition of the human norm. Once we can reduce a human being's physical appearance, personality, behavior, and aptitude to a sequence of nucleotides, we have reached the culmination of normativity. Every human being could be compared to the ideal 'human' simply by cross-referencing several thousand genetic polymorphisms.

The published goal of the Human Genome Project is a 'human reference sequence'. This sequence would correspond to no single human individual, but rather would represent the 'average' human genetic sequence. The identities of those who contributed DNA to the project remain secret for privacy reasons, but it is known that the private effort conducted by Celera Genomics was based upon the DNA of five donors of various ethnic backgrounds. The public side of the project, meanwhile, worked with a large though unspecified number of donors. Of importance to us is that the strategies of both sides of the project reveal the normative interests at hand. Even the term 'human reference sequence' suggests a norm by which we may all be compared to an ideal.

Foucault would certainly have found this notion alarming. Through such an exact knowledge of the biological essence of the human, individuals could be subjectified on a scale never before reached. It would be a total reconstitution of human meaning, on the level of the body. Of course, many people completely unfamiliar with Foucault's philosophy have had similar fears about government invasion of our genetic privacy, but Foucault's notion of biopower takes that fear to another level. Governmentality, through the utilization of such genetic knowledge, would only strengthen its hold, not just on our biological lives, but also on our ethico-moral values.

The clearest example of the threat posed by genetics would be in the eugenics movement supported by National Socialism. Foucault had a deep interest in fascism and its control of life and the body, for it represented the highest level of governmentality. Eugenics, as it was argued for both in Germany and in non-fascist states such as the U.S., saw the genetic integrity of the human race as vitally important. Those who would improve the genetic stock of the race were encouraged to breed. Racial minorities, the retarded, those of physical inferiority were all perceived as a threat to the existence of the human race, and in the case of Nazi Germany were subjected to programs designed to remove them from the genetic pool, through either separation or execution. Eugenics extended into the ethical life as well, with the continuity of the population seen as a moral obligation to the individual, and those behaviors which could interfere with that obligation seen as vices—hence a popular argument against homosexuality, which neglected the act of reproduction.

Early 20th-century eugenics certainly offers a bleak reminder of where our modern understanding of genetics could lead, but eugenics could potentially take on a new form in genetic engineering. The early-20th century eugenics movement focused more on a kind of selective breeding; under modern biotechnology, we will soon

be capable of directly altering the genetic composition of human beings in numerous ways. Medicine will be able to intervene in the human body—to "dictate the standards for physical and moral relations of the individual and of the society in which he lives"—in entirely new ways. Human performance could be enhanced by somatic cell gene therapy, character could be made to conform through behavioral genetics, and the ideal body could conceivably be reproduced in astonishing exactitude through cloning.

Now let me pause here to respond to any charges of alarmism my previous descriptions have surely opened me up to. I do not mean to suggest that a Foucauldian bioethics necessarily subscribes to a Brave New World hostility towards biotechnology. But Foucault would certainly see the potential for increased subjectification in the genetic era, and would argue against any attempt to humanize biotechnology—to present it as a beneficent practice, an attempt to contribute to the common good of mankind. The dangers of humanist medicine only increase when the science of genetics is added to the fold.

It is now common wisdom amongst bioethicists that both physicians and researchers must take into account the ethical consequences of their work. While on the surface this seems like a laudable attitude, there is a hidden danger in ascribing to it completely. Joanne Finkelstein expresses it well: "When knowledge becomes a source of power, as it does with technical or formal knowledge, it is the technocrat, the owner and controller of knowledge, who gains social power."[8] If all ethical responsibility is placed with the scientist or the doctor, then we place our ethical values in the hands of those with knowledge and power. In short, we surrender our morality—we are subjectified.

So where does genetics leave us? Foucault might say that it leaves us bound by a knowledge-power axis which defines the very essence of humanity in terms of our biology, and forces us to evaluate our ethical discourse more closely than ever before to escape a genetic reductionism. Genetics may be seen as the fullest attempt by man to define himself in scientific terms, but this requires us to consider our willingness to accept science and technology as the measure of human progress, as Finkelstein so rightly points out. Genetics has the dangerous potential to equate man's value with the sum of his abilities. If this danger is realized, then all the corresponding dangers hailed by alarmist anti-biotechnology advocates could conceivably follow: genetic discrimination, homogenization of the human race, the abandonment of the dignity of the individual, the biological commodification of humankind. Such ideas would be unsettling to most, to say the least. But can anything be done about it?

What is so unsettling about such a Foucauldian notion of genetics, and a bioethics in general, is that we are left with few constructive options for counter-attack. One of those options begins with Foucault's famous line that "the rallying point for the counterattack against the deployment of sexuality ought not to be sex-desire, but bodies and pleasures"[9]. This applies not just to sexual ethics, but to ethics in general, and bioethics in particular. We must think not in terms of ideologies, but in terms of corporeal realities, whether they be physical bodies per se or concrete practices. We must not sit back and engage idly in ethical discourse; we must be involved in an ethico-political practice, attempting to reshape the social-institutional structure while simultaneously living the ethical life.

This prescription no doubt sounds frustratingly vague, but perhaps a useful illustration of a starting point for ethical practice as it relates to medicine and biotechnology can be found in the response to the AIDS epidemic.

AIDS and Counter-Attack

When the AIDS epidemic began in the mid-1980s, society's response stayed true to certain discourses: AIDS was a homosexual disease, a disease of drug users and deviants. The average white, heterosexual, middle-class individual was considered safe. AIDS was linked to perceived immoralities, sexual and otherwise. In other words, the AIDS patient of the 80s was identified in comparison to the social norm.

However, this discourse changed as the AIDS epidemic became more and more pervasive. AIDS infected all sexual orientations, races, and economic backgrounds without discrimination. As the virus itself refused to be identified in relation to social categories, it became increasingly futile to define the AIDS patient in such a way. This forced a change in medical and social discourse about AIDS, and this change was brought about by the corporeal, not the ideological. The physical circumstances of the AIDS epidemic were so unique that traditional medical discourse could not deal with it in the same ways as with other diseases. This forced new and innovative ways of thinking and talking about AIDS—in short, the Gaze was restructured.

In the past decade, though, discourse has caught up, so that AIDS treatment is increasingly subject to administrative decisions and the AIDS patient is becoming normalized across new, broader scientific lines. Still, we may see some encouragement in the way discourse about AIDS, for a period of some years, managed to

escape the constraints of traditional medical and ethical discourse. This is perhaps the surest sign we have seen, medical or otherwise, that a Foucauldian ethico-political revision is at least possible. A detailed comparative study of the discourse on AIDS at it took place during three different stages—the initial years of the epidemic, the transitional period during which the public became more educated about the disease, and the current stage which began when drug cocktails made the disease a non-terminal one—would be an interesting investigation on how novel discourses, as described by Foucault, are incorporated into the social structure.

Of course, discourse is only the first step. Institutions must be reformulated across broad lines, and power relationships must be redefined. But the early years of the AIDS epidemic provide a promising example of how this first step could take place.

Conclusion

So where are we left in our pursuit of a Foucauldian bioethics? We must begin with discourse, examining how medicine and biotechnology came to be problematized. Through the practice of parrhesia we may critically evaluate this ethical discourse and the way in which it affects our lives, and moreover we may communicate the ethical truths we individually accept to others in the socio-political forum. By such a 'care of the self', we heal not only our own bodies, but the social body as well. This takes place, not through the sharing of ideologies, but through practice. Political action would then lead to broad institutional reforms which reflect ethical values independent of the accepted ethical discourse supported by biopower.

Some points of inquiry, more specific to bioethics, with which to begin our reflection: who should possess knowledge about our medical condition and our genetic information? How should this knowledge be used? Is social medicine based upon a beneficent attitude towards humankind, or is it a covert control mechanism? What value should be placed upon our genetic identities? How can relationships be restructured in order to loosen the grips of biopower? To what extent should the advance of biotechnology, and science in general, be considered as a measure of human progress?

A Foucauldian bioethics perhaps offers the most complete explanation of what broad social progress in medicine and biotechnology would involve. This proposal is intimidating, to say the least. But if the goals of bioethical reflection are worth the attention currently devoted to them, then we must regard the effort to reach them—no matter how arduous—worthwhile.

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1 Foucault, Michel. The Birth of the Clinic: An Archaeology of Medical Perception. 1973. Vintage Book: New York (p 34)

2 Foucault uses the term 'clinic' (la clinique) in reference to both the teaching hospital and clinical medicine in general. The teaching hospital, as the location of practice and education, and the introduction of clinical medicine (a medicine focused on the patient rather than the pathology, the disease) were epistemologically and historically linked, and so Foucault treats them as one in much of his work.

3 For a more detailed examination of the German, French, and English systems of social medicine discussed below, see Foucault, Michel. "The Birth of Social Medicine" in Power: The Essential Works of Foucault 1954-1984, Vol. III. Paul Rabinow, Ed. 1998. New Press: New York (p 134-156)

4 supra note 1 (pg 34)

5 See the posthumously published Foucault, Michel. Fearless Speech. 2001. Semiotext: Los Angeles (p 34)

6 Porto, Eugenia M. "Social Context and Historical Emergence: The Underlying Dimension of Medical Ethics" in 11 Theoretical Medicine 1990 (p 145-165)

7 "Relations of power-knowledge are not static forms of distribution, they are 'matrices of transformation'". Here, Foucault's use of the word 'transformation' certainly supports the idea that power relationships may be revised, and suggests that such a revision may be an integral part of the ethico-political process. See Foucault, Michel. The History of Sexuality Vol. 1: An Introduction. 1976. Vintage Book: New York (p 99)

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THE IMPLICATIONS OF THE RISE OF DIRECT-TO-CONSUMER ADVERTISING

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One cannot turn on the television, or flip through the pages of a magazine without seeing or reading an advertisement for a prescription drug. Prior to 1997, the great majority of drug advertisements were targeted at medical professionals. During the 1992 SuperBowl, however, a nicotine patch commercial was aired, the first prescription drug television advertisement intentionally directed at consumers. Although the product had been available months before, many consumers were not aware of its availability.[6] The public response to the ad was so great that the demand for the product began to exceed the supply. Recent Food and Drug Administration (FDA) guidelines have now relaxed restrictions and made direct-to-consumer (DTC) advertising possible. The pharmaceutical industry spent a total of $2.47 billion on DTC advertising in 2000.[12] Although some feel that DTC advertising can act as a tool to educate consumers about their health, others feel that the ads are uninformative, deceptive, and misleading. This paper will examine the implications of direct-to-consumer advertising with respect to the health of consumers, the role of physicians, and the legal and moral responsibilities of drug manufacturers.

In 1962, amendments were made to the Food, Drug, and Cosmetic Act in which FDA responsibility was increased to include regulation of pharmaceutical effectiveness and safety, giving it power over prescription drug advertising, which previously belonged to the Federal Trade Commission. In the early 1980s, several drug companies attempted to advertise to consumers until the FDA declared a moratorium on DTC advertising by pharmaceutical companies. This moratorium was lifted in 1985 but the FDA mandated that DTC advertising meet the same standards as advertising aimed at medical professionals. Print ads had to include a detailed "brief summary" of the risks associated with the drug and other information. Broadcast ads had to contain a "major statement" of risks and direct consumers to where they could obtain the full FDA-approved prescribing information. The FDA regulations were reinterpreted again in August 1997 with the release of the preliminary "Guidance for Industry: Consumer-Directed Broadcast Advertisements", which eased the requirements for the mandatory risk information statement.[4] These guidelines mandate the following: the ad must present fair and balanced information about drug efficacy and risk information; it must include a detailed major statement that communicates all vital risk information and relevant information in consumer-friendly language; and it must communicate all information relevant to the product's indication of usage. The FDA announced that it would re-evaluate the policy in 2 years and invited comments on its guidelines. In 1999, a FDA-commissioned survey of DTC advertisements was performed which found that there was no compelling evidence that DTC advertising had caused any harm. Again, the FDA announced that the guidelines would be reviewed in 2 years, and another consumer survey would be conducted, as well as a survey targeting physicians.[3]

Direct-to-consumer pharmaceutical advertising differs from other types of regulated advertising in two distinct ways. First, the advertised product requires a prescription from a physician in order for the consumer to obtain it. This can result in negative and positive externalities, or unintended secondary consequences. It can cost consumers time, inconvenience, and money to meet with a physician. However, consumers can benefit from visiting a doctor by hearing about the benefits and risks of a treatment protocol from a trained medical professional. A downside for the pharmaceutical company is that the nature of the product delays the effects of advertising by creating a time lag as compared to non-prescription products which consumers can purchase immediately. Secondly, DTC drug advertising is governed by tight FDA regulations. The FDA does not necessarily review each ad, but it investigates the truth behind therapeutic claims. It is the responsibility of the FDA to ensure that a drug will be advertised only for those conditions for which it has been proven effective.[3]

Benefits and Burdens

Pharmaceutical companies promote DTC advertising as consumer education, exposing countless patients to valuable health information that they can use to facilitate a discussion with their personal physician. The National Health Council, which consists of voluntary health associations and professional and membership organizations, believes that DTC ads can act as a valid patient education tool. Surveys of members of African-American and Latino medical professional associations reveal that the majority believe that DTC advertisements can promote education among minority populations who may not have easy access to medical professionals. Advertisements can provide initial information about symptoms and etiology of common disorders, thus motivating patients to visit their physician for a detailed examination.

Bell, Wilkes, and Kravitz conducted a study in 2000 to evaluate the content of DTC advertisements for the kind of information being presented to consumers. Advertisements from 18 popular magazines were examined to see if they contained 6 types of drug treatment information and 5 specific types of information pertaining to the medical condition of interest. The results showed that 95% of the advertisements evaluated provided the name of the medical condition and 60% provided details about the symptoms associated with that medical condition. Only 11%, however, presented prevalence information while only 9% presented information about misconceptions associated with the condition or the people affected by it. Alternative treatments were only mentioned in 29% of ads and the success rates of the advertised treatments were only presented in 9% of ads. This study therefore suggests that the information contained in DTC advertisements is superficial and does not provide basic information about prevalence, risk, or alternative treatments. The authors of the study suggested that the medical community lobby for regulation of advertisements so that more useful health and drug information be included.[1]

DTC advertising also increases patient drug compliance, a benefit touted by both patients and pharmaceutical companies because non-compliance may lead to increased health problems and higher health care costs. In a study conducted by Pfizer, Inc. and RxRemedy, 25,000 panelists were tracked via a monthly diary to see if patient request of drugs increased compliance.[10] The study found that for 5 major advertised conditions, patients who asked their doctor for a specific drug during the course of treatment were more "persistent" than those who let their doctor specify the drug. Compliance was also greater when patients requested a drug at the initial diagnosis compared to those who allowed their doctor to prescribe a drug.[9] These results suggest that patients motivated by advertisements would be more compliant than those merely prompted by a visit with their physician. However, compliance may also be affected by the quality of the patient-physician relationship rather than the influence of pharmaceutical advertising. Open communication between patients and physicians often leads to a more active patient role in his or her health care, thereby increasing compliance without respect to DTC advertising. The quality of the patient-physician relationship may therefore supercede advertising's effects.

DTC advertising may also cause the overall cost of prescription drugs to rise; drug companies compensate for advertising because increased pharmaceutical consumption heightens demand. In 2001, the estimated cost of retail spending of prescription drugs in the United States was $154.5 billion, a 17.1% increase from the previous year. This trend might be explained by an increase in the incidence and prevalence of chronic conditions and an increase in promotion of new drugs to both physicians and consumers. Prescribing newer, more expensive drugs rather than older, generic ones was in fact responsible for a "shift effect" that accounted for an estimated 24% of the rise in spending last year.[8] An increase in the price of drugs only accounted for 37% of the 2001 increase in retail spending, however. In 2001, 18.5% of drug company profits were spent on research, and in 2000, the research-based pharmaceutical industry spent 40% more on Research and Development (R&D) than on marketing of drugs.[11]

Although DTC advertising could possibly lead to an increase in retail spending by directly or indirectly causing a shift effect and an increase in prescriptions, this is not necessarily a negative effect if people who been left undiagnosed are prompted by DTC ads to visit their doctors. On the other hand, this might lead to inappropriate prescribing of unnecessary drugs. Physicians may be stimulated to prescribe a drug because of patient request and not because it is the most effective and appropriate medication, resulting in overmedication, undermedication, increased costs, and a deterioration of public health. Calfee, however, states that the most effective drugs tend to be underused rather than overused, and although evidence does in fact show that DTC advertising can increase the consumption of some expensive drug brands, such as antihistamines or arthritis analgesics, and decrease the use of generic brands, a possible economic burden on consumers and managed care, this tendency is not necessarily detrimental to patients' health.[3] The FDA does not seem concerned that

DTC advertising leads to inappropriate prescribing or the risks associated with it.

Patient-Physician Relationship

Pharmaceutical companies argue that DTC advertisements will build bridges between patients and physicians by encouraging consumers to consult their physicians. It is assumed that while they are in their doctor's office asking for a prescription, patients will discuss the risks and benefits and alternative treatments. According to Alan Holmer, president of Pharmaceutical Research and Manufacturers of America, "[DTC] advertising that encourages millions of Americans to consult their physicians can help to improve public health because a number of leading diseases are under-diagnosed and under-treated."[6] Dr. Richard Kravitz, the director of the Center for Health Service Research in Primary Care, also states that "recent studies have shown beyond a doubt that DTC advertising motivates discussions between patients and physicians about pharmaceutical product."[7]

Kravitz, however, expresses concern that these discussions might narrowly focus on brand-name drugs and detract from a broader discussion of the patient's health. DTC ads rarely mention alternative treatments, such as behavioral changes or non-pharmacological treatments, and as a result, patients usually do not consider these options before talking to their physicians. Patients may even become angry and consider switching physicians if their physician refuses to prescribe a requested advertised drug. Rather than building bridges, discussions about advertised drugs might actually burn bridges between physicians and patients.

Legal and Ethical Issues

Originally, pharmaceutical companies only targeted their advertising at medical professionals, since they would serve as the "learned intermediary" between pharmaceutical companies and consumers.[5] Physicians were thus responsible for discussing the potential risks and benefits of a drug, while pharmaceutical companies had no legal responsibilities to warn consumers. A 1966 liability lawsuit brought against a drug company for failure to warn physicians about a drug's serious health risks established this learned intermediary role while asserting the simultaneous responsibility of pharmaceutical companies (ibid). The federal court created a hierarchy of responsibility in which the pharmaceutical company was obligated to warn physicians about potential negative health effects, and physicians were obligated to interpret these warnings for their patients. The advent of DTC advertising, however, bypasses the advice of the physician, a potential negative effect.

When pharmaceutical companies present drug advertisements to consumers, the lay population believes it is being presented with truthful and relevant health information. Recent court rulings now mandate that drug companies take responsibility for warning patients about the potential risks of their drugs. In *Perez vs. Wyeth Laboratories* (1999), the New Jersey Supreme Court ruled that pharmaceutical companies were not liable in the past because of communication barriers between the drug-makers and patients. Now that contact between patients and physicians has diminished due to physician time constraints and increased advertising, however, the drug companies' influence over consumers has increased. Consequently, companies that participate in DTC advertising are held accountable and must adequately warn consumers about potential harms. By using advertisements to present treatment choices to patients, pharmaceutical companies assume the role previously delegated to physicians: a legal obligation to provide accurate information.

The ethical debate over DTC advertising concerns the complicated issues of autonomy, agency, and paternalism. According to Zachry and Ginsburg, autonomy means self-governance pertaining to liberty, or independence from controlling influences. A patient's autonomy can be violated when pharmaceutical advertising is intentionally biased or misleading in order to sway consumer behavior. The FDA does not require that information on disease prevalence and drug success rate be included in DTC advertising and many advertisements leave this vital information out, as shown in the Bell, Wilkes, and Kravitz study. Even if consumers are presented with unbiased facts, they still might choose not to read them. Several studies have shown that a very small percentage of consumers actually take the time to read the complete product information in a print pharmaceutical ad.[13]

As for agency, or the capacity for understanding and intentional action (ibid), a patient needs to be presented with all pertinent information needed to make a decision and base his or her intentional actions on that understanding. If a DTC advertisement does not present full information on a drug, such as risks, success rates, and alternative treatments, then it can be considered a potential violation of a patient's agency. It must be remembered that pharmaceutical manufacturers are businesses; their end goal is to make a profit by selling their products. Thus their drug advertisements make their products sound appealing to consumers by stressing the benefits and downplaying, or even omitting, the risks. The very nature of advertising, in fact, is to promote

the positive qualities of a product while downplaying its negative aspects. In an analysis of advertisement content, Bell et al found that the most popular appeals included the following terms: "effective", appearing in 57% of advertisements, and "controls symptoms" and "innovative", in 41%. The authors of the study expressed the most concern with regard to the fact that more than two-fifths of the ads marketed the product as "innovative"; consumers may not be aware that newer drugs may not have many advantages over older drugs and that the toxicity of new drugs is not always completely known. Moreover, only 5% of advertisements had "economical" appeals. Research has shown that price comparisons of competing drugs could potentially lead to lower costs. The drug advertisements evaluated in this study failed to include this type of information.[2]

Recommendations and Conclusions

More research must be performed to determine full effects of DTC advertising upon the rights of patients, physicians, and pharmaceutical companies. The available research shows that DTC advertising may stimulate patients to become more involved in the management of their health by developing physician-patient relationships of higher quality. Yet a drug advertisement should not substitute the advice of a medical professional. Consumers need to be aware that even though DTC advertisements present health information, they should be evaluated for missing or biased information. To curb the use of misleading information, FDA regulations should mandate that all advertisements include information about prevalence and incidence of the disease, success rate of the advertised drug, and available alternative treatments. Even though DTC advertisements can make patients more active participants in their health care, causing improved compliance and health maintenance, the advertising industry's role should not be overestimated. The influence of direct-to-consumer advertising should never supercede the patient's ultimate source of medical knowledge--the physician.

Author Biography

Amy Abraham is a senior at Tufts University majoring in Biology and Community Health. This article was originally a paper written for her Bio 97: Contemporary Biosocial Problems class. She would like to thank Dr. Ross Feldberg for his help with the original draft.

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